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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION—LOS ANGELES

EMSURGCARE, AND EMERGENCY SURGICAL ASSISTANT,

Plaintiff,

vs.

AMAZON.COM, INC. AND DOES 1-10.,

Defendants.

Case No. 2:24-cv-07418-ODW-MAA

DECLARATION OF ERIC GRAWE IN SUPPORT OF AMAZON'S MOTION TO DISMISS THE COMPLAINT FOR QUANTUM MERUIT

Hearing Date: November 18, 2024
Time: 1:30 p.m.
Complaint Filed: July 10, 2024
Removed: August 30, 2024

The Hon. Otis D. Wright, II

I, Eric Grawe, declare as follows:

1. I am a resident of Cook County in the State of Illinois. I am over the age of 18 years, of sound mind, and fully competent to make this Declaration.

2. I serve as a Sr. Benefits Specialist, US Benefits Operations Management, at Amazon, and am familiar with the matters set forth in this Declaration. In that role, I have access to information regarding the Amazon employer-sponsored benefit plans in which Amazon employees, and their dependents or domestic partners, are enrolled and can obtain copies of their respective plans and other plan related documents.

3. Attached as **Exhibit A** is a true and correct copy of excerpts of the Shared Deductible Plan, which was applicable to the patient that received the services at issue in the Complaint on those dates of service.

I declare under penalty of perjury under the laws of the United States and California that the foregoing is true and correct.

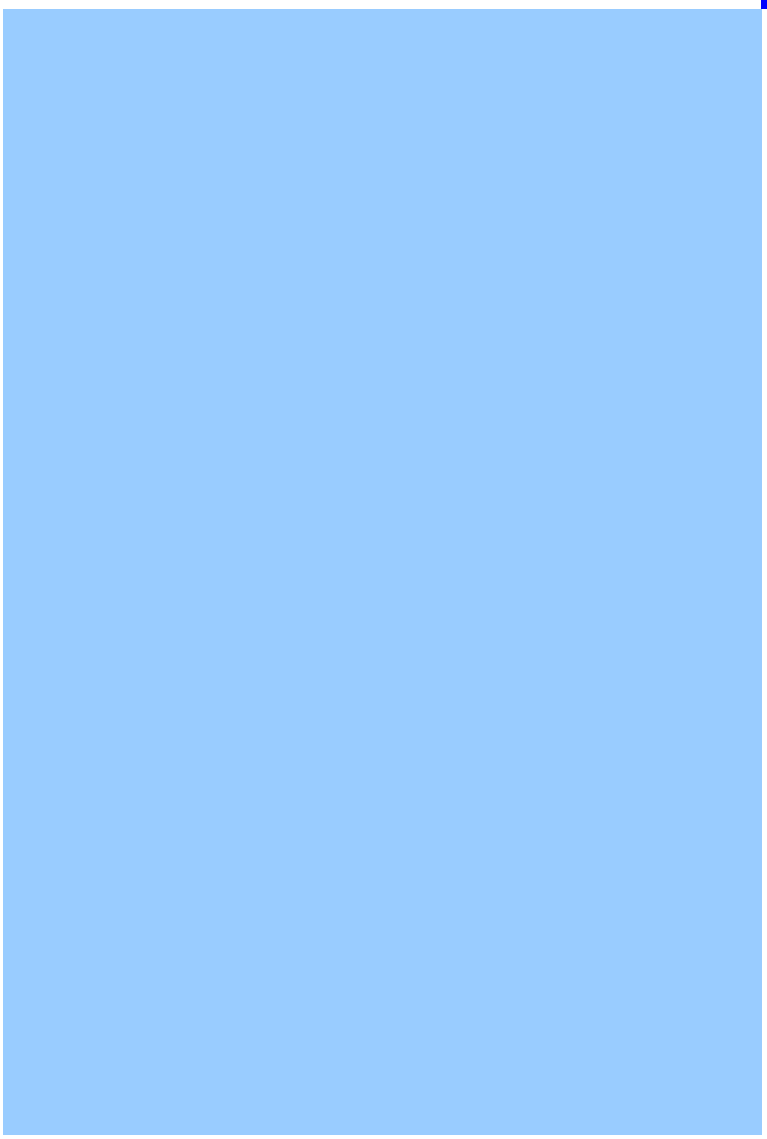
Executed on October 7, 2024 in Chicago, Illinois.

DocuSigned by:
/s/ Eric Grawe
1A1769F77CD342C...
Eric Grawe

EXHIBIT A

Shared Deductible Plan

Amazon and Subsidiaries



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*Defines the Terms Shown in Bold Type in the Text of This Document.

Introduction

The Group Health and Welfare Plan is an employer-sponsored, self-funded health and welfare plan. The Schedule of Benefits and Booklet serve as the Summary Plan Description ("SPD") for the Shared Deductible Plan (the "Shared Deductible Plan" or "Plan"), one of the medical benefit options available to you and your covered dependents under the Group Health and Welfare Plan that is administered by **Aetna**. This SPD includes a Schedule of Benefits and a Booklet.

The Summary Plan Description describes the Shared Deductible Plan, which is a component of the Group Health and Welfare Plan. The Shared Deductible Plan is self-funded by Amazon, the Employer, and participating subsidiaries/related employers (currently except for Zoox, Zappos.com, Inc., and Whole Foods Market, Inc.). Amazon is financially responsible for the payment of Shared Deductible Plan benefits. Amazon has the final discretionary authority to determine eligibility for benefits and construe the terms of the Plan.

Amazon has contracted with **Aetna** to adjudicate claims and perform other administrative duties. **Aetna** has been delegated the discretionary authority to determine claims for benefits and to construe the terms of the Shared Deductible Plan to the extent necessary to perform its services. **Aetna** doesn't insure the Shared Deductible Plan. To Receive benefits under the Shared Deductible Plan, including but not limited to utilizing the services of providers and pharmacies, you must abide by the provider/pharmacy's associated terms of use. This Summary Plan Description replaces and supersedes any other previous printed or electronic health plan benefit booklet or Summary Plan Description you may have for the Shared Deductible Plan.

The terms and conditions of the Shared Deductible Plan (administered by **Aetna**) are set forth in this Summary Plan Description and the formal Group Health and Welfare Plan document. This Summary Plan Description is incorporated by reference into the formal plan document. Together, they constitute the written instruments under which the Shared Deductible Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Shared Deductible Plan. Except with respect to the deadline to bring legal action, if there is a conflict between the formal plan document and this Summary Plan Description, the plan document controls.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

Please note: Effective January 1, 2022, the Plan Year is changing from an April 1 – March 31 plan year to a January 1 – December 31 plan year.

Exhaustion of Internal Appeals Process
Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

A rule violation was minor and is not likely to influence a decision or harm you; and
It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals
Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this Booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the

comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

Aetna's review of your appeal will take into account all comments, documents, records, and other information submitted by you relating to your claim, regardless of whether they were submitted or considered during the initial benefit determination. When considering your appeal, no deference will be given to the initial Adverse Benefit Determination. The review will not be conducted by the same individual who made the initial Adverse Benefit Determination or his or her subordinate. If the initial Adverse Benefit Determination was based in whole or in part on medical judgment, **Aetna** will consult with a health care professional with appropriate training and experience in a field of medicine involved in the medical judgment and who was not consulted in connection with the Adverse Benefit Determination or his or her subordinate. Upon request, **Aetna** will identify any medical or vocational experts whose advice was obtained in connection with making the appeal decision, without regard to whether the expert's advice was relied upon.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

If your appeal was denied, in whole or in part, the written notice will include:

- Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, the denial code and its corresponding meaning and the diagnosis and treatment codes and their corresponding meaning (or a statement describing the availability of the codes and their meanings, upon request)
- A description of **Aetna**'s standard, if any, used in denying the claim
- The reasons for the denial and a reference to the provisions of this Plan on which it's based

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal only);
- A statement of your right to bring a civil action under Section 502(a) of ERISA following appeal;
- Disclosure of any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- If the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
- A description of the external review process, if applicable; and
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review.

Health Claims – Voluntary Appeals

External Review
"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization ("ERO") or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

ERISA Plan Identifying Information

The Shared Deductible Plan (the "Plan") is a component of the Group Health and Welfare Plan, an employee welfare benefit plan that is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan Sponsor and Plan Administrator listed below, are the sponsor and administrator for the Group Health and Welfare Plan, of which the Shared Deductible Plan is a component.

Name of Benefit Component:

Shared Deductible Plan (a component of the Group Health and Welfare Plan).

Name and Address of Plan Sponsor

Amazon.com Services LLC
P.O. Box 81207
Seattle, WA 98108-1207
(206) 266-1000

Employer Identification Number:
82-0544687

Group Health and Welfare Plan Number:
501

Type of Benefit Component:
Self-funded employee medical component of a group health and welfare plan.

Type of Benefit Component Administration:
Third-party administration for claims and certain administrative services. The third-party administrator has discretionary authority to interpret and administer the Plan and to make factual determinations. Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Amazon.com Services LLC
P.O. Box 81207
Seattle, WA 98108-1207
(206) 266-1000

Agent For Service of Legal Process:

Amazon.com Services LLC
P.O. Box 81207
Seattle, WA 98108-1207
(206) 266-1000

Service of legal process may also be made upon the Plan Administrator

Address for Filing Claims:
Aetna
P.O. Box 14079
Lexington, KY 40512

Address for Filing Appeals:
Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

Funding Medium
This benefit component is self-funded and paid from the general assets of the Employer. No benefits are payable by an insurance company.

Source of Contributions

Contributions will be paid out of the Employer's general assets and through contributions paid by eligible employees, in the amounts determined by the Employer in its discretion.

Plan Year:
Effective January 1, 2022, the Plan Year is the period of 12 consecutive months that starts each January 1 and ends on the next December 31. For 2021, there was a short Plan Year that started on April 1, 2021 and ended on December 31, 2021.

Amazon Number
868402-868404

ERISA Rights
As a participant in the Group Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Group Health and Welfare Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Group Health and Welfare Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Group Health and Welfare Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Group Health and Welfare Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Group Health and Welfare Plan, called "fiduciaries" of the Group Health and Welfare Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $

110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Third Party Administrators

COBRA Administration - BenefitConnect
BenefitConnect | COBRA
DEPT: COBRA
P.O. Box 981915
El Paso, TX 79998
1.877.29COBRA (26272) (858-314-5108 International only)
https://cobra.ehr.com

EAP – Resources for Living
www.resourcesforliving.com/amazon
1-833-721-2323

Eligibility – Benefits Service Center
www.amazon.ehr.com
1-866-644-2696

Assisted Reproduction Benefits – Progyny

progyny.com/find-a-provider
1-855-369-3343

Health Savings Account/Flexible Spending Accounts – Fidelity (Not subject to ERISA)

www.netbenefits.com/amazon
1-800-835-5095